STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	01/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN 46228

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for an investigation of complaint #IN00162396. This visit was in conjunction with the post-certification revisit (PCR) survey to the recertification and state licensure survey completed on 11/12/14. Complaint #IN00162396: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W157, W240 and W331. Survey dates: January 13, 14, 15 and 21, 2015 Facility Number: 000961 Provider Number: 15G447 AIM Number: 100244750 Surveyor: Paula Eastmond, QIDP-TC These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/27/15 by Ruth Shackelford, QIDP.	W000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Governing Body for 2 of 4 sampled clients (B and C) and for 1 additional client (H). The governing body failed to ensure the facility did not neglect client C, conducted thorough investigations in regard to neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures/actions were taken to protect client C from falls. Findings include: 1. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 2 of 4 sampled clients (B and C) and for 1 additional client (H). The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client C in regard to falls. The governing body failed to ensure the facility conducted thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H. The governing body failed to ensure the facility developed corrective	W000102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically, the governing body has facilitated the following: The investigation into Client H's discovered injury on 11/5/14 has been located. The Residential Manager responsible for failing to complete thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. **ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Body will assume complete responsibility for investigating any discovered**	02/20/2015

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	actions/measures for client C in regard to falls which occurred in the bathroom. Please see W122. 2. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of the client in regard to falls in the bathroom to prevent potential falls and injuries for client C. The governing body failed to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures were put in place for client C in regard to monitoring and supervision. The governing body failed to ensure the facility conducted thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H. The governing body failed to ensure the facility put in place corrective measures to prevent client C from falling in the bathroom. Please see W104. This federal tag relates to complaint #IN00162396. 9-3-1(a)		**injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.** Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced supervision –line of sight observation and 15 minute checks while in her bedroom. A bed alarm and audio monitor will be placed in her	

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			bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all time while client C is toileting and showering. **PREVENTION:** **ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific**	

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			components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health	

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			and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Operations Team	
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 4 sampled clients (B and C) and for 1 additional client (H), the governing body failed to exercise general policy and operating direction over the facility to ensure the facility did not neglect client C, conducted thorough	W000104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, the governing body has facilitated the following: The investigation into Client H's discovered injury on 11/5/14 has been located.	02/20/2015

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	investigations in regard to neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures/actions were taken to protect client C from falls. Findings include: 1. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of the client in regard to falls in the bathroom to prevent potential falls and injuries for client C. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its written policy and procedures to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures were put in place for client C in regard to monitoring and supervision. Please see W149. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility conducted thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H. Please see W154.		The Residential Manager responsible for failing to complete thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. **ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.** Client C has begun receiving	

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	3. The governing body failed to exercise general policy and operating direction over the facility to put in place corrective measures to prevent client C from falling in the bathroom. Please see W157. This federal tag relates to complaint #IN00162396. 9-3-1(a)		twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced supervision –line of sight observation and 15 minute checks while in her bedroom. A bed alarm and audio monitor will be placed in her bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all time while client C is toileting and showering.	

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			PREVENTION: **ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program**	

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			Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members. The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the	

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			Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Operations Team	
W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review the facility failed to meet the Condition of Participation: Client Protections for 2 of 4 sampled clients (B and C) and for 1 additional client (H). The facility failed to implement its written policy and procedures to prevent neglect of client C in regard to falls. The facility failed to conduct thorough investigations in regard to all allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H. The facility failed to ensure corrective measures were put in place for client C in regard to falls which occurred in the bathroom. Findings include:	W000122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically: The facility has located the investigation into Client H's discovered injury on 11/5/14. The Residential Manager responsible for failing to complete thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. **ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with**	02/20/2015

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	1. The facility failed to implement its written policy and procedures to prevent neglect of the client in regard to falls in the bathroom to prevent potential falls and injuries for client C. The facility failed to implement its written policy and procedures to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures were put in place for client C in regard to monitoring and supervision. Please see W149. 2. The facility failed to conduct thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H. Please see W154. 3. The facility failed to put in place corrective measures to prevent client C from falling in the bathroom. Please see W157. This federal tag relates to complaint #IN00162396. 9-3-2(a)		**gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.** Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the	

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			following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced supervision –line of sight observation and 15 minute checks while in her bedroom. A bed alarm and audio monitor will be placed in her bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all time while client C is toileting and showering. **PREVENTION:** **ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly**	

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			to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team	

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W000149	483.420(d)(1)		**members.** The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, interview and record review for 2 of 4 sampled clients (B and C) and for 1 additional client (H), the facility neglected to implement its written policy and procedures to prevent neglect of the client in regard to falls in the bathroom to prevent potential falls and injuries. The facility neglected to implement its written policy and procedures to conduct thorough investigations in regard to allegations of abuse, neglect and/or injuries of unknown source for clients B, C and H, and to ensure corrective measures were put in place for client C in regard to the client's falls. Findings include: 1. During the 1/13/15 observation period between 5:04 PM and 6:45 PM and the 1/14/15 observation period between 6:14 AM and 8:30 AM, at the group home, client C utilized a wheelchair for mobilization. Client C did not wear a seatbelt when in the wheelchair. Client C wore a gait belt around the client's waist. Specifically during the 1/13/15 observation period, client C sat forward on the edge of wheelchair seat. Client C was verbally redirected to sit/scoot back	W000149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: The facility has located the investigation into Client H's discovered injury on 11/5/14. The Residential Manager responsible for failing to complete thorough investigations of Client C's falls and Client B, C and H's injuries of unknown origin has been removed from the facility and no longer serves in a formal supervisory capacity. **ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any**	02/20/2015

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	in the wheelchair and to sit up straight. During the 1/14/15 observation period, upon arrival, there were 2 direct care staff (staff #4 and #6) and the group home manager (staff #1) at the group home. Staff #6 was assisting clients to get up and get dressed and staff #1 was assisting client #8 to prepare breakfast. Staff #4 was in the medication room passing the morning medications. Staff #4 stayed in the medication room the entire observation period except to come out of the medication room to get clients for her morning medications. Staff #4 did not assist with the breakfast meal when clients were not getting medications. Staff #4 wore a nasal oxygen tube while carrying a portable oxygen container with her. During the 1/14/15 above observation period, client C required stand by and/or physical assistance when transferring from her wheelchair to the couch. Staff #1 physically assisted client C to stand while grabbing the client's gait belt to steady the client during the transfer. Client D required staff assistance when walking as the client was blind. Client E required staff physical assistance as well when ambulating as the client used a walker and wore a gait belt for transfers. Client B required staff supervision and monitoring due to the client's behavior of trying to get into the kitchen to drink tea (coffee).		**evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.** Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced supervision –line of sight observation and 15 minute checks while in her bedroom. A bed alarm and audio monitor will be placed in her bedroom. The team will also provide a modified toilet seat	

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	The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -11/11/14 "Upon arrival to group home [client C] (An individual Supported by Rescare) had just been assisted off the van and into the group home by staff. As the staff continued to assist the other individuals off the van (sic) [client C] wheeled herself into the bathroom without asking someone to assist her. While [client C] was in the bathroom she proceeded to take off her brief and pants causing her to fall to her knees causing an (sic) half inch in diameter injury to the right knee. The area was cleaned with peroxide and ointment applied to the area and covered with bandaide (sic)...[Client C] has a high risk plan for falls in place and staff will continue to implement her plan and give her moral support. The interdisciplinary team will be meeting to determine other ways to ensure [client C's] safety." -12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on her head where I brushed. I asked her		with side rails. The nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all time while client C is toileting and showering. **PREVENTION:** **ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they**	

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	what was wrong (sic) she stated that she fell as she got up off the toilet and hit her head on the toilet seat." The IAR indicated "...There is a scratch that is a (sic) inch long it is red and sore to the touch (sic)." The facility's 12/31/14 follow-up report to the 12/12/14 reportable incident report indicated "[Client C's] injury has healed and no further medical treatment was needed. In doing the investigation it was reported from the staff that worked that evening [client C] was assisted to the bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high risk plan for falls and will monitor [client C] more closely." The facility's 12/12/14 attached witness statements/investigation in regard to the injury of unknown source indicated only 2 direct care staff were interviewed in regard to client C's injuries. The staffs' witness statements indicated the following: -Staff #7 was interviewed on 12/12/14. Staff #7's witness statement indicated "No she didn't fall at least I don't think she did. I didn't take her and usually she		**are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations. Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.** The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team	

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	would tell me if she fell. She would like (sic) 'I fall, I fall'." -Staff #8 was interviewed on 12/12/14. Staff #8's witness statement indicated "She didn't fall. I assisted her to the bathroom. I assisted on the toilet and off and into bed. No she didn't fall cause if she did we would of (sic) needed to assist her up together." The facility's 12/12/14 investigation indicated the facility attempted to interview all 8 clients who lived in the group home. The facility's investigation indicated client H was interviewed on 12/12/14 at 5:45 PM. Client H's witness statement indicated "I didn't actually see [staff #7] put [client C] on the toilet. I think I seen (sic) her [staff #7] bring [client C] to the bathroom and put her on the toilet and told her not to move and [client C] got up on her own and fell. I was in the living room and heard [client C] yell. I didn't see anything. I was in the living room." The facility's investigation neglected to indicate any additional follow-up interviews and/or questions were conducted in regard to above mentioned statements. The facility's investigation did not indicate the environment was checked, did not have a conclusion, and/or indicate any additional recommendations for corrective actions.		and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	The facility's 12/12/14 investigation indicated the Qualified Intellectual Disabilities Professional (QIDP) conducted the facility's investigation. -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet. Preliminary inquiry suggests staff followed the protocols in the plan. The team is nonetheless investigating the circumstances of the incident to assure staff provided appropriate supports...." The facility's 12/15/14 IAR indicated "Staff was assisting [client C] with			

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	morning hygiene and had her seated on toilet. While staff was at face basin [client C] leaned over and immediately toopled (sic) over on to the floor. Staff noticed blood forming under the left side of her face...." The IAR indicated client C had "...about a half inch cut on forehead...." The 12/15/14 IAR was filled out by staff #9. The facility's 12/15/14 investigation indicated staff #4 was also working at the time of the incident. The facility's 12/15/14 investigation indicated staff #4 was interviewed on 12/15/14. Staff #4's witness statement indicated "...I (staff #4) do not know. Only thing I know when I came out of the other bathroom, [staff #9] had knocked on the door and told me [client C] had fell (sic) and it is so much blood. I came out of the bathroom and saw [client C] lying on her left side. So I instructed [staff #9] to call the nurse. [Staff #9] came back and told me nurse said to call 911 and she did. I said to [staff #9] just let her lay until Amb. (ambulance) comes." The facility's 12/15/14 investigation indicated client C was interviewed on 12/15/14. Client C's witness statement indicated the client fell in the bathroom at the back of the house. The witness statement indicated client C could not			

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	identify the staff who was with her. Client H's 12/15/14 witness statement indicated client H did not see when the incident occurred. Client H's witness statement indicated "...I didn't see I just heard them talking [staff #9] and [staff #4]...No, I just heard [staff #9] ask [staff #4] to help her. I was in my room getting dressed." An attached 12/15/14 Progress Note indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility neglected to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client C while she was in			

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	the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet, and/or indicate why client C was being washed while sitting on the toilet. The facility's investigation did not indicate where each staff was specifically located when client C fell off the toilet. The facility's investigation neglected to address/put in place corrective measures to protect client C from potential falls in the bathroom and/or injuries. The facility's 12/15/14 investigation indicated the facility neglected to look at their staffing levels to ensure the staff, who work, could meet the needs of the clients. The facility's 12/15/14 investigation indicated the QIDP completed the investigation. Client C's record was reviewed on 1/14/15 at 1:16 PM. Client C's 12/15/14 Record Of Visit (ROV) indicated client C was seen at a local hospital due to a fall. The ROV indicated client C had a "Forehead laceration. Normal head CT (cat scan) and cervical spine CT. Keep wound dry for 24 hours then wash as usual. Watch for signs of infection. Recommend PT for strengthening and fall prevention." Client C's 12/12/14 ROV indicated client C was seen at the ER due to a fall. The ROV indicated "Frontal Forehead			

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	bruising & (and) Abrasion. Forehead contusion/Abrasion. Head Injury instructions. Tylenol for pain." Client C's 12/15/14 nurse note indicated the facility's nurse went to the group home to assess client C after she returned from the ER. The nurse note indicated the nurse had watched facility staff transfer the client from the wheelchair to the bed and from the wheelchair to the commode using a gait belt and pivot to assist with the transfer. The nurse note indicated "...Consumer had a folded up piece of gauze covering the wound on forehead from fall, secured with transparent medical tape. Staff reported that while in the ER, the doctor there used a glue-like substance to close the wound together. Staff also reported that the ER doctor had advised not to cleanse the area until the next day. The size of the wound was approx. (approximately) 1 inch in length...Consumer was present during the IDT meeting, and it was discovered that she 'scoots' herself around in her wheelchair, but she leans forward in order to do this." Client C's nurse notes and/or record indicated the facility neglected to indicate when and/or if a PT evaluation had been set up/scheduled. Client C's 5/13/14 Health Supports Addendum indicated client C has an			

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	unsteady gait. The addendum indicated "...In the past, [client C] has had several injuries as a result of falls; therefore [client C] currently utilizes a wheelchair...Even though [client C] utilizes a wheelchair, she still continues to require prompting to use it properly and requires assistance to move into seats from her wheelchair...She will continue to have a PT evaluation annually...." Client C's 5/13/14 Individual Support Plan (ISP) indicated "...3.) [Client C] does not utilize proper precautions when ambulating her wheelchair, despite staff prompting her otherwise. She needs several redirections to make sure her seat belt is fasten (sic), the team agreed to continue this goal (to utilize her wheelchair in an appropriate manner). 4.) [Client C] is still having slight problems in asking for assistance in doing things that require her to get out of her wheelchair...In the past, [client C] has been noted as falling when trying to move out of her wheelchair." Client C's undated Decreased Mobility High Risk Health Plan indicated client C used a wheelchair for all mobility. The risk plan indicated "...4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home			

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	ambulation exercises. 6. Staff to provide at least standby assistance during showering/bathing/toileting. 7. Should fall occur NOTIFY the nurse immediately...." Client C's record indicated client C had ResCare's undated policy titled FALL PREVENTION PROTOCOL in the client's record. The undated policy indicated "POLICY: Falls occur among people who are weak, fatigued, uncoordinated, paralyzed, confused or disoriented. The data obtained from the fall risk assessment will identify which individuals require special measures to prevent falls. The risk for falls can be reduced by several factors as outlined below. PROCEDURE: 1. Staff should orient the person to the environment. 2. Staff should provide nonskid footwear, mats and rugs. 3. Adequate lighting in the environment. 4. Close supervision, when applicable. 5. Place beds in lowest appropriate position as defined by the IDT.			

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6. Side rails up if applicable.

7. Provide ambulatory aids, when applicable.

8. Assess medications administered that increase risk of falling.

9. Should fall occur staff will notify nurse immediately...

13. IDT will meet to discuss individualized fall prevention per ISP/BSP (Behavior Support Plan) or other safety protocols, when applicable."

Client C's record indicated the following IDT Meeting notes (not all inclusive):

-11/6/14 Client C's IDT met to follow up on falls and ER visit. The IDT note indicated on 7/26/14 "...[Client C] fell out (sic) the bed getting out without asking for assistance. The team decided to put her wheelchair away from her bed so she can call for help. Staff also have to redirect her housemate not to try to help without staff assistance...."

-11/19/14 "...[Client C] fell in the bathroom trying to toilet herself independently. Staff will push [client C] to the bathroom as soon as she gets off

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	the van and assist her to prevent future falls." -12/15/14 "12/12/14 - [Client C] had a scratch on her head that was noticed by staff when they were brushing her hair. [Client C] said she fell. [Client C] is unable to get herself off the floor so an investigation is being conducted to determine what happened. -12/15/14- [Client C] fell off the toilet while completing her ADL's (Adult Daily Living skills). Staff said she turned to wash out the face towel and [client C] some how lost balance and fell off the toilet. Staff assisted [client C] off the floor. [Client C] had a gash on her forehead. She was taken to ER where she was treated and released. As a prevention method [client C] needs a seat belt for her wheelchair. The team also discussed [client C] having her gait belt secured around her and the safety bars when she is on the toilet to prevent her falling. [Client C] would also benefit from a bed and chair alarm to alert staff when she is trying to get out the chair with assistance (sic). If any of these suggestions require HRC (Human Rights Committee approval it will be obtained after this plan is reviewed by the management committee." Client C's above mentioned IDT meeting notes, ISP and/or record indicated the facility			

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VOCA CORPORATION OF INDIANA	4114 KNOLLTON RD INDIANAPOLIS, IN 46228

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	neglected to develop a specific risk plan in regard to client C's falls. Client C's above mentioned IDT notes and/or record also indicated the facility neglected to specifically indicate how facility staff were to monitor/supervise client C while in the bathroom to prevent potential falls and/or injuries. Confidential interview A stated client C had fallen in the past, but had "no falls lately." Confidential interview A indicated staff were to be in the bathroom with client C when she was in the bathroom. Confidential interview A stated "She can't stand on her own." When asked how many staff normally work in the morning, confidential interview A stated "Two for the most part." Confidential interview B stated when asked how client C was to be supervised/monitored in the bathroom, "Help her in there. Help on commode. Maneuver to sit down and hold onto gait belt. We come out and then she calls us when ready. We go back in there and help her up and hold onto gait belt." Confidential interview B indicated client C was to hold on to the safety bar in the bathroom as well. When asked how often client C fell, confidential interview B stated "Not that much. She will jump			

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	up from wheelchair unlocked and fall. We hear hollering and find her on floor." Interview with staff #4 on 1/14/15 at 7:35 AM indicated client C fell last month. Staff #4 stated a staff was giving the client a "sponge off. Turned to rinse wash cloth off. She (client C) fell on floor." When asked if client C had fallen on the floor before, staff #4 stated "Quite a few times, but not fallen on my shift." Interview with Clinical Supervisor (CS) #1, the QIDP and LPN #1 on 1/14/15 at 3:35 PM indicated client C was a fall risk. The CS indicated 2 staff (staff #4 and staff #9) were working on 12/15/14 when client C fell off the toilet. CS #1 and the QIDP indicated staff #9 was in the bathroom when client C fell off the toilet. The QIDP indicated she did not question staff as to why client C was being washed off on the toilet. The QIDP and CS #1 indicated there were no additional staff interviews/conducted. CS #1 and the QIDP indicated the facility did not obtain a witness statement from staff #9. CS #1 indicated staff #9 filled out the incident report and the facility considered that her witness statement. When asked how the client fell off the toilet, the QIDP stated "She leaned forward and fell." The QIDP and CS #1 indicated the facility's investigation did			

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	not look at how client C was placed/sat on the toilet by staff to ensure the client was properly placed on the toilet. CS #1 indicated 2 facility staff normally worked in the morning. CS #1 and the QIDP indicated staff #4 was 1 of the 2 staff who worked on the morning shift. CS #1 indicated the facility neglected to look at staffing levels at the group home to ensure the facility staff, who worked in the home, could meet the needs of the clients. The QIDP indicated client C's IDT met and reviewed the falls and made recommendations. LPN #1 and the QIDP indicated client C was to see the PT on 1/15/15. The QIDP and LPN #1 indicated the IDT's recommendations to obtain a seat belt and wheelchair/bed alarms had not been purchased as they were waiting on the PT evaluation to be completed. The QIDP and LPN #1 indicated facility staff were to stay in the bathroom with client C when she was bathing and being toileted to prevent the client from falling. The QIDP and CS #1 indicated the facility did not conduct any additional interviews in regard to client C's injury of unknown source of 12/12/14. QIDP #1 indicated client C had indicated she fell. The QIDP and CS #1 indicated only 2 staff were interviewed and they did not know how client C received the injury to the client's head. The QIDP indicated facility staff			

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	indicated client C did not fall. When asked if client C's fall risk plan had been updated, LPN stated "No." The QIDP and LPN #1 indicated client C's mobility risk plan and/or record did not indicate how facility staff were to monitor client C when in the bathroom to prevent potential falls and/or injuries. 2. The facility failed to conduct thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H. Please see W154. 3. The facility failed to put in place corrective measures to prevent client C from falling in the bathroom. Please see W157. The facility's policy and procedures were reviewed on 1/14/15 at 11:02 AM. The facility's 2/26/11 policy entitled Abuse, Neglect, and Exploitation indicated "Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of Adept, Rescare, and local, state and federal guidelines." The			

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	facility's policy defined neglect as "...Failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment...." The facility's 2/26/11 policy also indicated the facility's investigations would indicate/include "...Methods (corrective actions) to prevent future incidents." This federal tag relates to complaint #IN00162396. 9-3-2(a)			
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, interview and record review for 4 of 5 allegations of abuse, neglect and/or injuries of unknown source reviewed, the facility failed to conduct thorough investigations in regard to allegations of possible neglect and/or injuries of unknown source for clients B, C and H.	W000154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: The facility has located the investigation into Client H's discovered injury on 11/5/14. The Residential Manager responsible for failing to complete thorough investigations of Client C's falls has been removed from	02/20/2015

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	Findings include: 1. During the 1/13/15 observation period between 5:04 PM and 6:45 PM and the 1/14/15 observation period between 6:14 AM and 8:30 AM, at the group home, client C utilized a wheelchair for mobilization. Client C did not wear a seatbelt when in the wheelchair. Client C wore a gait belt around the client's waist. Specifically during the 1/13/15 observation period, client C sat forward on the edge of wheelchair seat. Client C was verbally redirected to sit/scoot back in the wheelchair and to sit up straight. During the 1/14/15 observation period, upon arrival, there were 2 direct care staff (staff #4 and #6) and the group home manager (staff #1) at the group home. Staff #6 was assisting clients to get up and get dressed and staff #1 was assisting client #8 to prepare breakfast. Staff #4 was in the medication room passing the morning medications. Staff #4 stayed in the medication room the entire observation period except to come out of the medication room to get clients for her morning medications. Staff #4 did not assist with the breakfast meal when clients were not getting medications. Staff #4 wore a nasal oxygen tube while carrying a portable oxygen container with her. During the 1/14/15 above observation period, client C required		the facility and no longer serves in a formal supervisory capacity. **ADDENDUM 2/17/15: The Operations Team, including the Program Manager and QIDP, will directly oversee all investigations. The Residential Manager will receive additional training toward assisting with gathering evidence, including conducting thorough witness interviews. The Clinical Supervisor and Program Manager will assure that conclusions are developed that match the collected evidence. The governing Body will assume complete responsibility for investigating any discovered injuries that require outside medical treatment. When any evidence of staff negligence is uncovered or alleged the Operations Team will take control of all aspects of the investigation process.** **PREVENTION:** **ADDENDUM 2/17/15: A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to**	

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	stand by and/or physical assistance when transferring from her wheelchair to the couch. Staff #1 physically assisted client C to stand while grabbing the client's gait belt to steady the client during the transfer. Client D required staff assistance when walking as the client was blind. Client E required staff physical assistance as well when ambulating as the client used a walker and wore a gait belt for transfers. Client B required staff supervision and monitoring due to the client's behavior of trying to get into the kitchen to drink tea (coffee). The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on her head where I brushed. I asked her what was wrong (sic) she stated that she fell as she got up off the toilet and hit her head on the toilet seat." The IAR indicated "...There is a scratch that is a (sic) inch long it is red and sore to the touch (sic)." The facility's 12/31/14 follow-up report		**facility supervisors and the Operations Team. The Clinical Supervisor (Administrative level management) will meet with his/her facility management teams weekly to review the progress made on all investigations that are open for their homes. Residential Managers will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five business day timeframe. The Clinical Supervisor will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. The Program Manager will also conduct spot checks of investigations, focusing on serious incidents that could potentially have occurred as a result of staff negligence. The Clinical Supervisors will provide weekly updates to the Program Manager on the status of investigations.**	

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	to the 12/12/14 reportable incident report indicated "...In doing the investigation it was reported from the staff that worked that evening [client C] was assisted to the bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high risk plan for falls and will monitor [client C] more closely." The facility's 12/12/14 attached witness statements/investigation in regard to the injury of unknown source indicated only 2 direct care staff were interviewed in regard to client C's injuries. The staffs' witness statements indicated the following: -Staff #7 was interviewed on 12/12/14. Staff #7's witness statement indicated "No she didn't fall at least I don't think she did. I didn't take her and usually she would tell me if she fell. She would like (sic) 'I fall, I fall'." -Staff #8 was interviewed on 12/12/14. Staff #8's witness statement indicated "She didn't fall. I assisted her to the bathroom. I assisted on the toilet and off and into bed. No she didn't fall cause if she did we would of (sic) needed to assist her up together."		**Failure to complete thorough investigations within the allowable five business day timeframe will result in progressive corrective action to all applicable team members.** **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Direct Support Staff, Operations Team	

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	The facility's 12/12/14 investigation indicated the facility attempted to interview all 8 clients who lived in the group home. The facility's investigation indicated client H was interviewed on 12/12/14 at 5:45 PM. Client H's witness statement indicated "I didn't actually see [staff #7] put [client C] on the toilet. I think I seen (sic) her [staff #7] bring [client C] to the bathroom and put her on the toilet and told her not to move and [client C] got up on her own and fell. I was in the living room and heard [client C] yell. I didn't see anything. I was in the living room." The facility's investigation did not indicate any additional follow-up interviews and/or questions were conducted in regard to above mentioned statements. The facility's investigation did not indicate the environment was checked, did not have a conclusion, and/or indicate any additional recommendations for corrective actions. The facility's 12/12/14 investigation indicated the Qualified Intellectual Disabilities Professional (QIDP) conducted the facility's investigation. -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting			

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	in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet. Preliminary inquiry suggests staff followed the protocols in the plan. The team is nonetheless investigating the circumstances of the incident to assure staff provided appropriate supports...." The facility's 12/15/14 IAR indicated "Staff was assisting [client C] with morning hygiene and had her seated on toilet. While staff was at face basin [client C] leaned over and immediately toopled (sic) over on to the floor. Staff noticed blood forming under the left side of her face...." The IAR indicated client C had "...about a half inch cut on forehead...." The 12/15/14 IAR was filled out by staff #9.			

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	The facility's 12/15/14 investigation indicated staff #4 was also working at the time of the incident. The facility's 12/15/14 investigation indicated staff #4 was interviewed on 12/15/14. Staff #4's witness statement indicated "...I (staff #4) do not know. Only thing I know when I came out of the other bathroom, [staff #9] had knocked on the door and told me [client C] had fell (sic) and it is so much blood. I came out of the bathroom and saw [client C] lying on her left side. So I instructed [staff #9] to call the nurse. [Staff #9] came back and told me nurse said to call 911 and she did. I said to [staff #9] just let her lay until Amb. (ambulance) comes." The facility's 12/15/14 investigation indicated client C was interviewed on 12/15/14. Client C's witness statement indicated the client fell in the bathroom at the back of the house. The witness statement indicated client C could not identify the staff who was with her. Client H's 12/15/14 witness statement indicated client H did not see when the incident occurred. Client H's witness statement indicated "...I didn't see I just heard them talking [staff #9] and [staff #4]...No, I just heard [staff #9] ask [staff #4] to help her. I was in my room getting dressed."			

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	An attached 12/15/14 Progress Note indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility failed to include an interview with staff #9, and/or any other staff who had worked with the client to determine if staff monitored client C while she was in the bathroom. The facility's investigation did not question and/or ask how client C was placed on the toilet, and/or indicate why client C was being washed while sitting on the toilet. The facility's investigation did not indicate where each staff was specifically located when client D fell off the toilet. The facility's 12/15/14 investigation indicated the facility failed to look at their staffing levels to ensure			

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	the staff, who worked, could meet the needs of the clients. The facility's 12/15/14 investigation indicated the QIDP completed the investigation. Client C's record was reviewed on 1/14/15 at 1:16 PM. Client C's 12/15/14 IDT Meeting note indicated on "12/12/14 - [Client C] had a scratch on her head that was noticed by staff when they were brushing her hair. [Client C] said she fell. [Client C] is unable to get herself off the floor so an investigation is being conducted to determine what happened. -12/15/14- [Client C] fell off the toilet while completing her ADL's (Adult Daily Living skills). Staff said she turned to wash out the face towel and [client C] some how lost balance and fell off the toilet. Staff assisted [client C] off the floor. [Client C] had a gash on her forehead. She was taken to ER where she was treated and released...." Confidential interview A stated client C had fallen in the past, but had "no falls lately." Confidential interview A indicated staff were to be in the bathroom with client C when she was in the bathroom. Confidential interview A stated "She can't stand on her own." When asked how many staff normally work in the morning, confidential interview A stated "Two for the most			

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	part." Confidential interview B stated when asked how client C was to be supervised/monitored in the bathroom, "Help her in there. Help on commode. Maneuver to sit down and hold onto gait belt. We come out and then she calls us when ready. We go back in there and help her up and hold onto gait belt." Confidential interview B indicated client C was to hold on to the safety bar in the bathroom as well. When asked how often client C fell, confidential interview B stated "Not that much. She will jump up from wheelchair unlocked and fall. We hear hollering and find her on floor." Interview with staff #4 on 1/14/15 at 7:35 AM indicated client C fell last month. Staff #4 stated a staff was giving the client a "sponge off. Turned to rinse wash cloth off. She (client C) fell on floor." When asked if client C had fallen on the floor before, staff #4 stated "Quite a few times, but not fallen on my shift." Interview with Clinical Supervisor (CS) #1, the QIDP and LPN #1 on 1/14/15 at 3:35 PM indicated client C was a fall risk. The CS indicated 2 staff (staff #4 and staff #9) were working on 12/15/14 when client C fell off the toilet. CS #1 and the QIDP indicated staff #9 was in			

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	the bathroom when client C fell off the toilet. The QIDP indicated she did not question staff as to why client C was being washed off on the toilet. The QIDP and CS #1 indicated there were no additional staff interviews/conducted. CS #1 and the QIDP indicated the facility did not obtain a witness statement from staff #9. CS #1 indicated staff #9 filled out the incident report and the facility considered that her witness statement. When asked how the client fell off the toilet, the QIDP stated "She leaned forward and fell." The QIDP and CS #1 indicated the facility's investigation did not look at how client C was placed/sat on the toilet by staff to ensure the client was properly placed on the toilet. CS #1 indicated 2 facility staff normally worked in the morning. CS #1 and the QIDP indicated staff #4 was 1 of the 2 staff who worked on the morning shift. CS #1 indicated the facility did not look at staffing levels at the group home to ensure the facility staff, who worked in the home, could meet the needs of the clients. The QIDP and CS #1 indicated the facility did not conduct any additional interviews in regard to client C's injury of unknown source of 12/12/14. QIDP #1 indicated client C had indicated she fell. The QIDP and CS #1 indicated only 2 staff were interviewed and they did not know how client C received the injury to			

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	the client's head. The QIDP indicated facility staff indicated client C did not fall. 2. The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -11/5/14 "The nurse was doing routine body checks at the group home. And when she examined [client H] (An individual Supported By Rescare) she noticed that both of [client H's] knees had a light pinkish color to them and the left knee had about a 2/3 (two third) size in diameter sore she had been picking at....An investigation is being conducted into the probable cause of the injury...." The facility did not provide any documentation of an investigation in regard to client H's injuries of unknown source. -11/5/14 The nurse was doing routine body checks in the group home. And when she examined [client B] (An Individual Supported by Rescare) she noticed a bruise on her right butt cheek a half size in diameter (sic). An observed			

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	incident which was reported on October 27, 2014 that [client B] had a behavior and plopped herself down on the ground and the staff assisted her up and when the staff arrived back to the home. (sic) [client B] was checked for bruising and at that time there was no bruising...An investigation will be conducted in to (sic) the probable cause of the injury...." The facility's 11/14/14 follow-up report to the 11/5/14 reportable incident indicated "In conducting the investigation it was not determined how the injury occurred. But it is addressed in [client B's] behavior support plan that she will drop herself to the ground to get attention from the staff...." The 11/5/14 reportable incident report and/or the 11/14/14 follow up report did not indicate the facility documented its investigation in regard to client B's injury of unknown source. Interview with CS #1 on 1/14/15 at 11:15 AM indicated the facility's investigations and reportable incident reports from 11/1/14 to the present were provided for review. CS #1 did not provide any additional documentation of investigations. This federal tag relates to complaint #IN00162396.			

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	9-3-2(a)			
W000157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on interview and record review for 1 of 5 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to put in place corrective measures to prevent client C from falling in the bathroom. Findings include: The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -11/11/14 "Upon arrival to group home [client C] (An individual Supported by Rescare) had just been assisted off the van and into the group home by staff. As the staff continued to assist the other individuals off the van (sic) [client C] wheeled herself into the bathroom without asking someone to assist her. While [client C] was in the bathroom she proceeded to take off her brief and pants	W000157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Specifically, Client C has begun receiving twice weekly physical therapy sessions and a daily home exercise program has been initiated to enhance Client C's core strength to diminish the incidence of falls such as occurred on 12/12/14 and 12/15/14. An Occupational Therapy evaluation has been scheduled for Client C to evaluate the effectiveness of current adaptive equipment and to obtain recommendations for enhancements. In the interim, after appropriate due process, the team will provide the following adaptive modifications: the seat belt will be re-fitted to Client C's wheelchair and a chair alarm will be installed to alert staff when the seat belt has become unfastened. Client C will receive enhanced supervision –line of sight observation and 15 minute checks while in her bedroom. A bed alarm and audio monitor will be placed in her bedroom. The team will also provide a modified toilet seat with side rails. The nurse will modify Client C's	02/20/2015

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	causing her to fall to her knees causing an (sic) half inch in diameter injury to the right knee. The area was cleaned with peroxide and ointment applied to the area and covered with bandaide (sic)...[Client C] has a high risk plan for falls in place and staff will continue to implement her plan and give her moral support. The interdisciplinary team will be meeting to determine other ways to ensure [client C's] safety." -12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on her head where I brushed. I asked her what was wrong (sic) she stated that she fell as she got up off the toilet and hit her head on the toilet seat." The IAR indicated "...There is a scratch that is a (sic) inch long it is red and sore to the touch (sic)." The facility's 12/31/14 follow-up report to the 12/12/14 reportable incident report indicated "[Client C's] injury has healed and no further medical treatment was needed. In doing the investigation it was reported from the staff that worked that evening [client C] was assisted to the bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high		Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all time while client C is toileting and showering. **PREVENTION: ADDENDUM 2/17/15: After completing investigations in which the allegations are verified, the QIDP, with the guidance of the Clinical supervisor and Program Manger, will bring all relevant elements of the interdisciplinary team together to develop corrective measures to ensure the heal and safety of clients.** The Residential Manager will develop and maintain a staffing matrix that assures adequate direct support staff who possess the training, skills and capabilities to provide appropriate active treatment and assure the health and safety of clients at all times. Members of the Operations Team and the QIDP will conduct active treatment observations and documentation reviews no less than five times weekly for the next 21 days, no less than 3 times weekly for an additional 14 Days, and no less than twice weekly for an additional 60 Days. At the conclusion of this period of intensive administrative	

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	risk plan for falls and will monitor [client C] more closely." The facility's 12/12/14 investigation indicated the 12/12/14 investigation did not have a conclusion, and/or indicate any additional recommendations for corrective actions. -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet...." The facility's 12/15/14 investigation indicated "IDT (interdisciplinary team)		monitoring and support, the Operations Team will determine the level of ongoing support needed at the facility. Administrative support at the home will focus on mentorship and training of supervisory staff, monitoring and coaching of direct support staff, and evaluation of the effectiveness of current risk plans and safety protocols. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team	

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	met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." The facility's investigation indicated the facility's investigation failed to address/put in place corrective measures to protect client C from potential falls in the bathroom and/or injuries. Interview with Clinical Supervisor (CS) #1, the QIDP and LPN #1 on 1/14/15 at 3:35 PM indicated client C's IDT met and reviewed the falls and made recommendations. LPN #1 and the QIDP indicated client C was to see the PT on 1/15/15. The QIDP and LPN #1 indicated the IDT's recommendations to obtain a seat belt and wheelchair/bed alarms had not been purchased as they were waiting on client C's PT (physical therapy) evaluation to be completed. The QIDP and LPN #1 indicated facility staff were to stay in the bathroom with client C when she was bathing and being toileted to prevent the client from falling. The QIDP and LPN #1 indicated client C's mobility risk plan and/or record did not indicate how facility staff were to monitor client C when in the bathroom to			

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	prevent potential falls and/or injuries. This federal tag relates to complaint #IN00162396. 9-3-2(a)			
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on interview and record review for 1 of 4 sampled clients (C), the client's Individual Support Plan (ISP) failed to indicate how facility staff were to monitor/supervise the client, when in the bathroom, to prevent falls/injuries. Findings include: The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -11/11/14 "Upon arrival to group home [client C] (An individual Supported by Rescare) had just been assisted off the van and into the group home by staff. As the staff continued to assist the other	W000240	**CORRECTION:** *The individual program plan must describe relevant interventions to support the individual toward independence.*Specifically, the facility nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all times while client C is toileting and showering. The team will also provide a modified toilet seat with side rails. Additional modifications may be made after Client C's scheduled Occupational Therapy appointment. A review of incident documentation and current risk plans indicated this deficient practice did not affect any	02/20/2015

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	individuals off the van (sic) [client C] wheeled herself into the bathroom without asking someone to assist her. While [client C] was in the bathroom she proceeded to take off her brief and pants causing her to fall to her knees causing an (sic) half inch in diameter injury to the right knee. The area was cleaned with peroxide and ointment applied to the area and covered with bandaide (sic)...[Client C] has a high risk plan for falls in place and staff will continue to implement her plan and give her moral support. The interdisciplinary team will be meeting to determine other ways to ensure [client C's] safety." -12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on her head where I brushed. I asked her what was wrong (sic) she stated that she fell as she got up off the toilet and hit her head on the toilet seat." The IAR indicated "...There is a scratch that is a (sic) inch long it is red and sore to the touch (sic)." The facility's 12/31/14 follow-up report to the 12/12/14 reportable incident report indicated "[Client C's] injury has healed and no further medical treatment was needed. In doing the investigation it was reported from the staff that worked that evening [client C] was assisted to the		additional clients. **PREVENTION:** The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team	

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	bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high risk plan for falls and will monitor [client C] more closely." -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet...." Client C's record was reviewed on 1/14/15 at 1:16 PM. Client C's 5/13/14 Health Supports Addendum indicated			

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	client C has an unsteady gait. The addendum indicated "...In the past, [client C] has had several injuries as a result of falls; therefore [client C] currently utilizes a wheelchair...Even though [client C] utilizes a wheelchair, she still continues to require prompting to use it properly and requires assistance to move into seats from her wheelchair...." Client C's 5/13/14 Individual Support Plan (ISP) indicated "...3.) [Client C] does not utilize proper precautions when ambulating her wheelchair, despite staff prompting her otherwise. She needs several redirections to make sure her seat belt is fasten (sic), the team agreed to continue this goal (to utilize her wheelchair in an appropriate manner). 4.) [Client C] is still having slight problems in asking for assistance in doing things that require her to get out of her wheelchair...In the past, [client C] has been noted as falling when trying to move out of her wheelchair." Client C's undated Decreased Mobility High Risk Health Plan indicated client C used a wheelchair for all mobility. The risk plan indicated "...4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide			

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	at least standby assistance during showering/bathing/toileting...." Client C's record indicated client C had ResCare's undated policy titled FALL PREVENTION PROTOCOL in the client's record. The undated policy indicated "POLICY: Falls occur among people who are weak, fatigued, uncoordinated, paralyzed, confused or disoriented. The data obtained from the fall risk assessment will identify which individuals require special measures to prevent falls. The risk for falls can be reduced by several factors as outlined below. PROCEDURE: 1. Staff should orient the person to the environment. 2. Staff should provide nonskid footwear, mats and rugs. 3. Adequate lighting in the environment. 4. Close supervision, when applicable. 5. Place beds in lowest appropriate position as defined by the IDT. 6. Side rails up if applicable.			

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	7. Provide ambulatory aids, when applicable. 8. Assess medications administered that increase risk of falling. 9. Should fall occur staff will notify nurse immediately... 13. IDT will meet to discuss individualized fall prevention per ISP/BSP (Behavior Support Plan) or other safety protocols, when applicable." Client C's record indicated the following IDT Meeting notes (not all inclusive): -11/6/14 Client C's IDT met to follow up on falls and ER visit. The IDT note indicated on 7/26/14 "...[Client C] fell out (sic) the bed getting out without asking for assistance. The team decided to put her wheelchair away from her bed so she can call for help. Staff also have to redirect her housemate not to try to help without staff assistance...." -11/19/14 "...[Client C] fell in the bathroom trying to toilet herself independently. Staff will push [client C] to the bathroom as soon as she gets off the van and assist her to prevent future falls."			

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	-12/15/14 "12/12/14 - [Client C] had a scratch on her head that was noticed by staff when they were brushing her hair. [Client C] said she fell. [Client C] is unable to get herself off the floor so an investigation is being conducted to determine what happened. -12/15/14- [Client C] fell off the toilet while completing her ADL's (Adult Daily Living skills). Staff said she turned to wash out the face towel and [client C] some how lost balance and fell off the toilet. Staff assisted [client C] off the floor. [Client C] had a gash on her forehead. She was taken to ER where she was treated and released. As a prevention method [client C] needs a seat belt for her wheelchair. The team also discussed [client C] having her gait belt secured around her and the safety bars when she is on the toilet to prevent her falling. [Client C] would also benefit from a bed and chair alarm to alert staff when she is trying to get out the chair with assistance (sic). If any of these suggestions require HRC (Human Rights Committee approval it will be obtained after this plan is reviewed by the management committee." Client C's above mentioned IDT notes and/or record indicated the facility failed to specifically indicate how facility staff were to monitor/supervise client C while in the bathroom to prevent potential falls and/or			

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	injuries. Confidential interview A stated client C had fallen in the past, but had "no falls lately." Confidential interview A indicated staff were to be in the bathroom with client C when she was in the bathroom. Confidential interview A stated "She can't stand on her own." Confidential interview B stated when asked how client C was to be supervised/monitored in the bathroom, "Help her in there. Help on commode. Maneuver to sit down and hold onto gait belt. We come out and then she calls us when ready. We go back in there and help her up and hold onto gait belt." Confidential interview B indicated client C was to hold on to the safety bar in the bathroom as well. When asked how often client C fell, confidential interview B stated "Not that much. She will jump up from wheelchair unlocked and fall. We hear hollering and find her on floor." Interview with staff #4 on 1/14/15 at 7:35 AM indicated client C fell last month. Staff #4 stated a staff was giving the client a "sponge off. Turned to rinse wash cloth off. She (client C) fell on floor." When asked if client C had fallen on the floor before, staff #4 stated "Quite a few times, but not fallen on my shift."			

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	15G447	A. BUILDING 00 B. WING	01/21/2015

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	Interview with Clinical Supervisor (CS) #1, the QIDP and LPN #1 on 1/14/15 at 3:35 PM indicated client C was a fall risk. The QIDP and LPN #1 indicated facility staff were to stay in the bathroom with client C when she was bathing and being toileted to prevent the client from falling. The QIDP and LPN #1 indicated client C's mobility risk plan and/or record did not indicate how facility staff were to monitor client C when in the bathroom to prevent potential falls and/or injuries. This federal tag relates to complaint #IN00162396. 9-3-4(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, interview and record review for 2 of 4 sampled clients (A and C), the facility's nursing services failed to meet the nursing needs of the clients in regard to developing and/or revising risk plans, addressing a client's significant change in weight (weight loss) and/or documenting pertinent health information of clients. Findings include:	W000331	**CORRECTION:** *The facility must provide clients with nursing services in accordance with their needs.* Specifically for Client A, the facility nurse will contact the dietician to collaborate on enhancements to Client A's	02/20/2015

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	1. During the 1/13/15 observation period between 5:04 PM and 6:45 PM, at the group home, client A was small in stature. During the 1/13/15 observation period, client A refused to eat dinner. Facility staff #7 offered the client a substitute which the client refused. Facility staff #7 then offered the client pineapple to eat. Staff #7 told client A she (staff #7) liked pineapple. Client A agreed she would eat the pineapple. When staff #7 got the bowl of pineapple, client A refused to eat the pineapple and went to her bedroom before returning to the couch to play solitaire Uno. During the 1/14/15 observation period between 6:14 AM and 8:30 AM, at the group home, client A refused to eat breakfast. Facility staff did not offer the client an alternate meal/food to eat. Client A's record was reviewed on 1/14/15 at 12:30 PM. Client A's December 2014 physician's orders indicated client A's diagnoses included, but were not limited to Diabetes Mellitus and Anemia. Client A's December 2014 physician's orders indicated facility staff should encourage "lower cholesterol snacks." The physician's orders also indicated "Offer second servings of meat at meals. May have snack/sandwich		comprehensive High Risk Plan for Weight Loss. Additionally the interdisciplinary team will modify Client A's Behavior Support Plan to include proactive and reactive strategies to address meal refusals. Specifically for Client C, the facility nurse will modify Client C's Comprehensive High Risk Plan for falls to clarify the expectations for "stand by" assistance while Client C is in the bathroom including but not limited to hands on use of a gait belt at all times while client C is toileting and showering. The team will also provide a modified toilet seat with side rails. Additional modifications may be made after Client C's scheduled Occupational Therapy appointment. A review of incident documentation and current risk plans indicated this deficient practice did not affect any additional clients. **PREVENTION:** The QIDP will assure that the nursing team is included in all discussions/decisions relevant to clients' health and safety and modifications will be made to Comprehensive High Risk Plans	

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	upon request including during the night due to weight loss." The December 2014 physician orders indicated client A should have 1 can of Glucerna 4 times a day as a nutritional supplement and a Glucerna bar at lunch and at bedtime for a nutritional supplement. Client A's November 2014 Nurse Notes (most current in the record) indicated client A weighed 83 pounds 1 month ago, 100 pounds 6 months ago and 100 pounds 1 year ago. The 11/14 nurse note did not have a current weight for client A. The area for the "Current Weight" was blank. The nurse note indicated client A's ideal body weight range was between 83 pounds and 101 pounds. Client A's 10/30/14 Group Home Nutrition Assessment indicated the following weights for client A: -9/13 100 pounds -10/13 100 pounds -11/13 100 pounds -12/13 95 pounds -1/14 98 pounds -2/14 100 pounds -3/14 96.6 pounds -4/14 95 pounds -5/14 100 pounds -6/14 96 pounds -7/14 "?" (question) no weight		accordingly. The nurse manager will review all reports of significant health and safety issues and will meet with the Operations Team weekly to discuss health and safety issues including but not limited to needed updates to risk plans. The nurse manager will review all facility risk plan modifications for the next 90 days to assure they contain appropriate detail, and will conduct periodic audits of facility risk plans on an ongoing basis. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Team Leader, Health Services Team, Direct Support Staff, Operations Team	

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	documented -8/14 95 pounds 9/14 "?" no weight documented. The 10/30/14 assessment indicated client A's current weight at the time of the assessment was 83 pounds. The assessment indicated "Weight down likely d/t (due to) scale change but current BMI (Body Mass Index) is low/below the rec. (recommended) range. Resident receives Glucerna supplement QID (4 times a day) for additional nutrition. Underweight as evidenced by BMI < (less than) 18.5...Goal -Weight gain of 2-3 # (pounds) x (times) 3 months.- BMI the rec. range (18.5-24.9). -Cont (continue) diet orders (with) Glucerna QID. -Offer snacks between meals and HS (bedtime) snack." Client A's 12/7/14 Individual Support Plan (ISP) indicated client A did not have a risk plan which addressed the client's low weight in her record. Client A's ISP and/or 12/7/14 Behavior Action Plan (BAP) did not address the client's refusals to eat, and/or indicate how/what the facility staff were to do to get client A to eat. Interview with LPN #1 and the Qualified Intellectual Disabilities Professional (QIDP) on 1/14/15 at 3:35 PM indicated client A would refuse to eat. LPN #1			

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	indicated client A's current weight was 85 pounds as of 12/31/14. LPN #1 stated client A had a "10 pound weight loss" in the past year. LPN #1 stated the weight loss was a "significant loss" for client A. LPN #1 indicated she had not addressed the client's weight loss. LPN #1 indicated client A had a supplement drink (Glucerna) the client was to receive if the client did not eat and/or finfish her meal. LPN #1 and the QIDP indicated facility staff should keep prompting the client to eat when she refused to eat. The QIDP indicated client A would not eat to get the supplemental drink as the client liked the drink. The QIDP and LPN #1 indicated client A's ISP did not indicate what facility staff were to do when client A refused to eat, and/or indicate how facility staff were to assist client A to eat. 2. The facility's reportable incident reports, the facility's internal Incident/Accident Reports (IARs) and/or investigations were reviewed on 1/14/15 at 11:17 AM. The facility's reportable incident reports, IARs and/or investigations indicated the following (not all inclusive): -11/11/14 "Upon arrival to group home [client C] (An individual Supported by Rescare) had just been assisted off the van and into the group home by staff. As			

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	the staff continued to assist the other individuals off the van (sic) [client C] wheeled herself into the bathroom without asking someone to assist her. While [client C] was in the bathroom she proceeded to take off her brief and pants causing her to fall to her knees causing an (sic) half inch in diameter injury to the right knee. The area was cleaned with peroxide and ointment applied to the area and covered with bandaide (sic)...[Client C] has a high risk plan for falls in place and staff will continue to implement her plan and give her moral support. The interdisciplinary team will be meeting to determine other ways to ensure [client C's] safety." -12/12/14 "As I (staff #5) brushed [client C's] head she was complaining of pain on her head where I brushed. I asked her what was wrong (sic) she stated that she fell as she got up off the toilet and hit her head on the toilet seat." The IAR indicated "...There is a scratch that is a (sic) inch long it is red and sore to the touch (sic)." The facility's 12/31/14 follow-up report to the 12/12/14 reportable incident report indicated "[Client C's] injury has healed and no further medical treatment was needed. In doing the investigation it was reported from the staff that worked that			

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	evening [client C] was assisted to the bathroom into her bed with no injuries occurring that evening. [Client C] however said that she had fell (sic) and could not remember when she fell. Staff are being retrained on [client C's] high risk plan for falls and will monitor [client C] more closely." -12/15/14 "Staff was assisting [client C] (individual supported by ResCare) with using the toilet. Staff turned to the side to rinse a washcloth and [client C] fell off the commode and hit her head resulting in a 1/2 (one half inch) laceration. Staff called 911 and EMS (Emergency Medical Services) transported [client C] to the [name of hospital] for evaluation and treatment via ambulance. ER (emergency room) personnel closed and dressed the injury and released [client C] to ResCare staff with wound care instructions. [Client C] is resting comfortably at home and staff will perform neuro (neurological) checks for 24 hours per protocol. [Client C] has a history of falls and a Comprehensive High Risk Plan is in place, the risk plan for falls directs staff to provide her with stand-by assistance while transferring to and from the toilet...." An attached 12/15/14 Progress Note to the facility's 12/15/14 investigation			

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	indicated "[Client C] had Nasty fall in the bathroom this AM, while being assist (sic) by staff member. Slid down off toilet as staff was trying to wash her. [Client C] fell forward and hit her head. Nurse was called and she stated to call emerg. (emergency). She was then taken to Hosp. (hospital) for observation." The facility's investigation indicated "IDT (interdisciplinary team) met and discussed the different ways to help prevent future falls such as seat belt for wheelchair and bed alarm to alert staff when she is getting out of bed or chair without assistance. Also a recommendation from ER physician to schedule for PT (Physical Therapy) apt. (appointment)." Client C's record was reviewed on 1/14/15 at 1:16 PM. Client C's 12/15/14 Record Of Visit (ROV) indicated client C was seen at a local hospital due to a fall. The ROV indicated client C had a "Forehead laceration. Normal head CT (cat scan) and cervical spine CT. Keep wound dry for 24 hours then wash as usual. Watch for signs of infection. Recommend PT for strengthening and fall prevention." Client C's 12/12/14 ROV indicated client C was seen at ER due to a fall. The ROV indicated "Frontal Forehead bruising &			

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	(and) Abrasion. Forehead contusion/Abrasion. Head Injury instructions. Tylenol for pain." Client C's 12/15/14 nurse note indicated the facility's nurse went to the group home to assess client C after she returned from the ER. The nurse note indicated the nurse had watched facility staff transfer the client from the wheelchair to the bed and from the wheelchair to the commode using a gait belt and pivot to assist with the transfer. The nurse note indicated "...Consumer had a folded up piece of gauze covering the wound on forehead from fall, secured with transparent medical tape. Staff reported that while in the ER, the doctor there used a glue-like substance to close the wound together. Staff also reported that the ER doctor had advised not to cleanse the area until the next day. The size of the wound was approx. (approximately) 1 inch in length...Consumer was present during the IDT meeting, and it was discovered that she 'scoots' herself around in her wheelchair, but she leans forward in order to do this." Client C's nurse notes and/or record indicated the facility's nurse failed to document when and/or if a PT evaluation had been set up/scheduled. Client C's 5/13/14 Health Supports Addendum indicated client C has an			

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	unsteady gait. The addendum indicated "...In the past, [client C] has had several injuries as a result of falls; therefore [client C] currently utilizes a wheelchair...Even though [client C] utilizes a wheelchair, she still continues to require prompting to use it properly and requires assistance to move into seats from her wheelchair...She will continue to have a PT evaluation annually...." Client C's 5/13/14 Individual Support Plan (ISP) indicated "...3.) [Client C] does not utilize proper precautions when ambulating her wheelchair, despite staff prompting her otherwise. She needs several redirections to make sure her seat belt is fasten, the team agreed to continue this goal (to utilize her wheelchair in an appropriate manner). 4.) [Client C] is still having slight problems in asking for assistance in doing things that require her to get out of her wheelchair...In the past, [client C] has been noted as falling when trying to move out of her wheelchair." Client C's undated Decreased Mobility High Risk Health Plan indicated client C used a wheelchair for all mobility. The risk plan indicated "...4. Staff to provide hands-on assistance when entering and exiting the van. 5. Staff to provide standby assistance during in home ambulation exercises. 6. Staff to provide			

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	at least standby assistance during showering/bathing/toileting. 7. Should fall occur NOTIFY the nurse immediately...." Client C's record indicated client C had ResCare's undated policy titled FALL PREVENTION PROTOCOL in the client's record. The undated policy indicated "POLICY: Falls occur among people who are weak, fatigued, uncoordinated, paralyzed, confused or disoriented. The data obtained from the fall risk assessment will identify which individuals require special measures to prevent falls. The risk for falls can be reduced by several factors as outlined below. PROCEDURE: 1. Staff should orient the person to the environment. 2. Staff should provide nonskid footwear, mats and rugs. 3. Adequate lighting in the environment. 4. Close supervision, when applicable. 5. Place beds in lowest appropriate position as defined by the IDT.			

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	6. Side rails up if applicable. 7. Provide ambulatory aids, when applicable. 8. Assess medications administered that increase risk of falling. 9. Should fall occur staff will notify nurse immediately... 13. IDT will meet to discuss individualized fall prevention per ISP/BSP (Behavior Support Plan) or other safety protocols, when applicable." Client C's record indicated the following IDT Meeting notes (not all inclusive): -11/6/14 Client C's IDT met to follow up on falls and ER visit. The IDT note indicated on 7/26/14 "...[Client C] fell out (sic) the bed getting out without asking for assistance. The team decided to put her wheelchair away from her bed so she can call for help. Staff also have to redirect her housemate not to try to help without staff assistance...." -11/19/14 "...[Client C] fell in the bathroom trying to toilet herself independently. Staff will push [client C] to the bathroom as soon as she gets off			

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	the van and assist her to prevent future falls." -12/15/14 "12/12/14 - [Client C] had a scratch on her head that was noticed by staff when they were brushing her hair. [Client C] said she fell. [Client C] is unable to get herself off the floor so an investigation is being conducted to determine what happened. -12/15/14- [Client C] fell off the toilet while completing her ADL's (Adult Daily Living skills). Staff said she turned to wash out the face towel and [client C] some how lost balance and fell off the toilet. Staff assisted [client C] off the floor. [Client C] had a gash on her forehead. She was taken to ER where she was treated and released. As a prevention method [client C] needs a seat belt for her wheelchair. The team also discussed [client C] having her gait belt secured around her and the safety bars when she is on the toilet to prevent her falling. [Client C] would also benefit from a bed and chair alarm to alert staff when she is trying to get out the chair with assistance (sic). If any of these suggestions require HRC (Human Rights Committee approval it will be obtained after this plan is reviewed by the management committee." Client C's above mentioned IDT meeting notes, ISP and/or record indicated the facility's			

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	nursing services failed to develop a specific risk plan in regard to client C's falls which indicated how facility staff were to monitor/supervise client C while in the bathroom to prevent potential falls and/or injuries. Confidential interview A stated client C had fallen in the past, but had "no falls lately." Confidential interview A indicated staff were to be in the bathroom with client C when she was in the bathroom. Confidential interview A stated "She can't stand on her own." Confidential interview B stated when asked how client C was to be supervised/monitored in the bathroom, "Help her in there. Help on commode. Maneuver to sit down and hold onto gait belt. We come out and then she calls us when ready. We go back in there and help her up and hold onto gait belt." Confidential interview B indicated client C was to hold on to the safety bar in the bathroom as well. Interview with staff #4 on 1/14/15 at 7:35 AM indicated client C fell last month. Staff #4 stated a staff was giving the client a "sponge off. Turned to rinse wash cloth off. She (client C) fell on floor." When asked if client C had fallen on the floor before, staff #4 stated "Quite			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a few times, but not fallen on my shift." Interview with Clinical Supervisor (CS) #1, the QIDP and LPN #1 on 1/14/15 at 3:35 PM indicated client C was a fall risk. When asked how the client fell off the toilet, the QIDP stated "She leaned forward and fell." The QIDP indicated client C's IDT met and reviewed the falls and made recommendations. LPN #1 and the QIDP indicated client C was to see the PT on 1/15/15. The QIDP and LPN #1 indicated the IDTs recommendations to obtain a seat belt and wheelchair/bed alarms had not been purchased as they were waiting on the PT evaluation to be completed. The QIDP and LPN #1 indicated facility staff were to stay in the bathroom with client C when she was bathing and being toileted to prevent the client from falling. When asked if client C's fall risk plan had been updated, LPN stated "No." The QIDP and LPN #1 indicated client C's mobility risk plan and/or record did not indicate how facility staff were to monitor client C when in the bathroom to prevent potential falls and/or injuries. This federal tag relates to complaint #IN00162396. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G447	A. BUILDING 00 B. WING	01/21/2015

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